



New York State Board for Professional Medical Conduct

433 River Street, Suite 303 • Troy, New York 12180-2299 • (518) 402-0863

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
*Commissioner
NYS Department of Health*

Dennis P. Whalen
*Executive Deputy Commissioner
NYS Department of Health*

Dennis J. Graziano, Director
Office of Professional Medical Conduct

PUBLIC

William P. Dillon, M.D.
Chair

Michael A. Gonzalez, R.P.A.
Vice Chair

Ansel R. Marks, M.D., J.D.
Executive Secretary

October 29, 2002

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Michael H. Klein, M.D.
1200 East Genesee Street
Syracuse, NY 13210

RE: License No. 122058

Dear Dr. Klein:

Enclosed please find Order #BPMC 02-335 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect October 29, 2002.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order to Board for Professional Medical Conduct, New York State Department of Health, Hedley Park Place, Suite 303, 433 River Street, Troy, New York 12180.

Sincerely,

Ansel R. Marks, M.D., J.D.

Executive Secretary

Board for Professional Medical Conduct

Enclosure

cc: Mark L. Dunn, Esq.
c/o Martin, Ganotis, Brown, Mould & Currie, P.C.
5790 Widewaters Parkway
DeWitt, NY 13214

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
MICHAEL H. KLEIN, M.D.

CONSENT
ORDER

Upon the application of (Respondent) **MICHAEL H. KLEIN, M.D.** in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

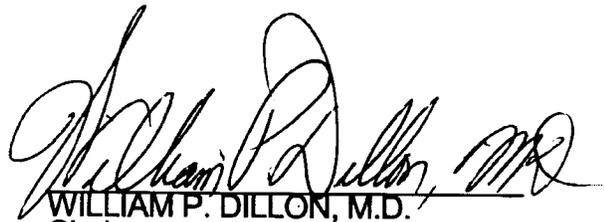
ORDERED, that the Consent Agreement, and its terms, are adopted and SO ORDERED, and it is further

ORDERED, that this Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney, Whichever is first.

SO ORDERED.

DATED: 10/28/02



WILLIAM P. DILLON, M.D.
Chair
State Board for Professional Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
MICHAEL H. KLEIN, M.D.

CONSENT
AGREEMENT
AND
ORDER

MICHAEL H. KLEIN, M.D., representing that all of the following statements are true, deposes and says:

That on or about September 25, 1974, I was licensed to practice as a physician in the State of New York, and issued License No. 122058 by the New York State Education Department.

My current address is 1200 East Genesee Street, Syracuse, New York, 13210, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct has charged me with Thirty-seven specifications of professional misconduct.

A copy of the Statement of Charges, marked as Exhibit "A", is attached to and part of this Consent Agreement.

I admit Factual Allegations D.2, D.6, D.7, G.1, G.4, H.1, H.5, and H.6 as they relate to the Fifteenth Specification [negligence on more than one occasion], in full satisfaction of the charges against me, and agree to the following penalty:

That my medical license in the State of New York shall be suspended for a period of five years, with the suspension period stayed so long as I remain at all times in compliance with the terms

of probation set out in Exhibit "B", attached hereto.

Additionally, I agree that, within 60 days of the effective date of the Order herein, I shall enroll in a program conducted by the Albany Medical Center that will evaluate my clinical skills in the area of obstetrics and gynecology, with particular emphasis in gynecologic surgery. As a condition of this agreement, I shall successfully complete any retraining or continuing education recommended by Albany Medical Center following the evaluation of my clinical skills, as noted above.

For a period of 5 years after the effective date of the Order, I shall be on probation as set out in Exhibit "B".

For a period of three years after the effective date of the Order I shall obtain pre-surgical approvals for gynecologic surgeries, as set out in Exhibit "B".

For a period of five years, I shall otherwise be monitored in my practice of medicine, as set out in Exhibit "B".

I shall enroll in and successfully complete continuing medical education for each of the next 5 [five] years, as set out in Exhibit "B".

I further agree that the Consent Order shall impose the following conditions:

That Respondent shall maintain current registration of licensure with the New York State Education Department Division of Professional Licensing Services (except during periods of actual suspension), and shall pay all registration fees. This condition shall take effect thirty (30) days after the Consent Order's effective date

and will continue so long as Respondent remains licensed in New York State; and

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State.

I stipulate that my failure to comply with any conditions of this Order shall constitute misconduct as defined by New York State Education Law §6530(29).

I agree that if I am charged with professional misconduct in future, this Consent Agreement and Order shall be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without

prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to the Public Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first.

I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and ask that the Board adopt this Consent Agreement.

DATED 10-8-2002


MICHAEL H. KLEIN, M.D.
RESPONDENT

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 10/2/02



MARK L. DUNN, ESQ.
Attorney for Respondent

DATE: 10/17/02



MICHAEL A. FISER, ESQ.
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 10/24/02



DENNIS J. GRAZIANO
Director
Office of Professional Medical Conduct

EXHIBIT "B"

Terms of Probation

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by New York State Education Law §6530 or §6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to New York State Public Health Law §230(19).
2. Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299 with the following information, in writing, and ensure that such information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty (30) days of each action.
3. Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.
4. Respondent's failure to pay any monetary penalty by the prescribed date shall subject Respondent to all provisions of law relating to debt collection by New York State, including but not limited to: the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].
5. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of thirty (30) consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive thirty (30) day period. Respondent shall then notify the Director again at least fourteen (14) days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period will resume and Respondent shall fulfill any unfulfilled probation terms.
6. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records and/or hospital charts; and interviews with or periodic visits with Respondent and Respondent's staff at practice locations or OPMC offices.
7. Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

8. Respondent shall obtain a clinical competency assessment performed by a program for such assessment as directed by the Director of OPMC. Respondent shall cause a written report of such assessment to be provided directly to the Director of OPMC within sixty (60) days of the effective date of this Order.
9. Upon completion of Phase I and within four months of the effective date of the Order, Respondent shall be enrolled in a course of personalized continuing medical education, which includes an assigned preceptor, preferably a physician board certified in the same specialty, to be approved, in writing, by the Director of OPMC. Respondent shall remain enrolled and shall fully participate in the program for a period of not less than three months nor more than twelve months.
10. Respondent shall cause the preceptor to
 - a. Submit reports on a quarterly basis to OPMC certifying whether Respondent is fully participating in the personalized continuing medical education program.
 - b. Report immediately to the Director of OPMC if Respondent withdraws from the program and report promptly to OPMC any significant pattern of non-compliance by Respondent.
 - c. At the conclusion of the program, submit to the Director of OPMC a detailed assessment of the progress made by Respondent toward remediation of all identified deficiencies.

PRACTICE MONITOR

11. After thirty days of the effective date of the order, and for a period of five years thereafter, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.
 - a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no less than 20%) of records of Respondent's surgical patients maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.
 - b. Respondent shall be solely responsible for all expenses associated

- with monitoring, including fees, if any, to the monitoring physician.
- c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.
 - d. Respondent shall maintain medical malpractice insurance coverage with limits no less than \$2 million per occurrence and \$6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.
 - e. After 3 years of such monitoring, Respondent may request in writing that this monitoring shall be discontinued. Such a request will be duly considered by the Director or his designee, who shall have full discretion to grant the request or to maintain the monitoring as set out in these Terms of Probation.
12. For a period of three years after the effective date of the Order herein, Respondent shall perform gynecologic surgeries done on a non-emergency basis, such as hysterectomy, diagnostic laparoscopy, dilation and curettage, cryosurgery, salpingo-oophorectomy, lysis of adhesions, Marshal-Marchetti-Krantz procedures, other procedures to treat pelvic floor disorders, or obtain cervical biopsies, only when pre-approved by a licensed physician, board certified in an appropriate specialty, ("pre-surgical monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.
- a. Respondent shall make available to the pre-surgical monitor any and all records or access to the practice requested by the monitor, including on-site observation and the entire office record of the patient, including all written lab or other test results, and a meeting with and evaluation of the patient where necessary. Such pre-surgical approval shall indicate, among others, whether the surgery proposed by the Respondent for the patient is medically indicated and whether all appropriate pre-operative testing has been performed. The pre-surgical monitor shall review the indications for surgery at least 48 hours before each such procedure, and shall record the monitor's written approval for the proposed procedure prior to the procedure. Any perceived deviation from accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.
 - b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the pre-surgery monitoring physician.
 - c. Respondent shall cause the pre-surgical monitor to report quarterly, in writing, to the Director of OPMC.
13. Respondent shall ensure that the pre-surgical monitor is familiar with the Order and terms of probation, and willing to report to OPMC. Respondent shall ensure that the pre-surgical monitor is in a position to regularly

observe and assess Respondent's medical practice. Respondent shall cause the pre-surgical monitor to report within 24 hours any suspected impairment, inappropriate behavior, questionable medical practice or possible misconduct to OPMC.

14. Respondent shall enroll in and complete a continuing education program in courses approved by the American college of Obstetricians and Gynecologists, such course to concern gynecologic evaluation, testing, and surgery including but not limited to courses in urodynamic testing, urogynecology/pelvic floor disorders, or management of gynecologic surgery and prevention of complications, for a minimum of 50 credit hours per year for each of the first 5 years after the effective date of the order herein. This continuing education program is subject to the Director of OPMC's prior written approval and shall be completed within the probation period, unless the Order specifies otherwise.
15. Respondent shall enroll in and successfully complete a course in the proper medical indications for and the techniques of performing colposcopies, within one year of the effective date of the order herein. Such course shall be subject to the approval of the Director or his designee.
16. Respondent shall comply with this Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
MICHAEL H. KLEIN, M.D.

STATEMENT
OF
CHARGES

MICHAEL H. KLEIN, M.D., the Respondent, was authorized to practice medicine in New York State on or about September 25, 1974, by the issuance of license number 122058 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. Respondent provided medical care to Patient A¹, a 41 year old female, at various times from approximately November 1992 to August 1999 at, among others places, the Respondent's office at 1200 East Genesee Street, Syracuse, New York 13210 ("Respondent's office") and at the Community General Hospital, Broad Road, Syracuse, New York ("Community General"). Respondent performed cryosurgery on Patient A in his office in August 1994; Respondent performed a total abdominal hysterectomy, bilateral salpingo-oophorectomy, and lysis of adhesions on Patient A in August 1999. Respondent's medical care of Patient A failed to meet accepted standards of medical practice in the following respects:
1. Respondent, in or about August 1994, performed cryosurgery on Patient A without adequate medical indications, and/or without adequately documenting such medical indications.
 2. Respondent, in his August 25, 1999 history and physical or other documentation prepared prior to the patient's total abdominal hysterectomy and bilateral salpingo-oophorectomy, recorded the following:

¹ Patient names are set forth on the attached "Appendix".

- A. that the patient had "a longstanding history of recurrent dysplasia";
- B. that the patient had "multiple colposcopies";
- C. that the colposcopies revealed progressive dysplasia from moderate to severe;
- D. that the patient's "recurrent" dysplasia was then "severe"; and

In fact, the patient had no history of recurrent dysplasia; she had undergone only one colposcopy; that one colposcopy had shown neither progression, nor moderate, nor severe dysplasia; and the patient did not have severe dysplasia at the time of the 8/25/99 surgical procedure.

- 3. Respondent, on or about August 25, 1999, performed a total abdominal hysterectomy on Patient A without adequate medical indication and/or without adequately or accurately documenting such medical indication.
- 4. Respondent, in his August 1999 discharge summary for the hysterectomy and related procedures, documented that the patient had specific laboratory findings of:
 - A. "hematocrit 31.2";
 - B. "hemoglobin 12.6"; and
 - C. "white blood cell count [of] 6,000."

In fact, the laboratory findings cited by the Respondent are not found in any documented lab report in the patient's admission of August 1999. Respondent knew or should have known these facts.

- 5. Respondent failed to adequately or accurately document his evaluation and/or treatment of this patient.

- B. Respondent provided medical care to Patient B, a 64 year old female, at various times from 1994 through at least 1999 at the Respondent's office and at the Community General Hospital. In September 1999, Respondent performed a laparoscopic procedure on Patient B, as well as a dilation and curettage, cervical biopsies, and aspiration of a right ovarian cyst. In December 1999, Respondent performed a total abdominal hysterectomy, bilateral salpingo-oophorectomy, lysis of adhesions, and a Marshall-Marchetti-Krantz procedure, on Patient B. Respondent's medical care of Patient B failed to meet accepted standards of medical practice in the following respects:

1. Respondent, in September 1999, performed a diagnostic laparoscopy, and cervical biopsies on Patient B, without adequate medical indication, and/or without adequately documenting such medical indication.
2. Respondent, in December 1999, performed a hysterectomy on Patient B without adequate medical indication, and/or without adequately or accurately documenting such medical indication.
3. Respondent, in December 1999, performed a Marshall-Marchetti-Krantz procedure on Patient B without adequate medical indication, and/or without adequately documenting such medical indication.
4. Respondent, in his December 1999 discharge summary for the hysterectomy and related procedures, documented that the patient had specific laboratory findings that included, among others:
 - A. "Urinalysis benign"; and
 - B. "Urine culture negative".

In fact, the findings represented by the Respondent were not in the documented medical record; no urinalysis was ordered or obtained; nor was a urine culture ordered or obtained. Respondent knew or should have known these facts.

5. Respondent failed to adequately or accurately document his evaluation and/or treatment of this patient.

C. Respondent provided medical care to Patient C, a 37 year old female, at various times from approximately 1996 through at least 2001 at the Respondent's office and at the Community General Hospital. Respondent performed cryosurgery on Patient C on or about July 17, 1996. Respondent, on or about January 14, 2000, also performed an abdominal hysterectomy, with bilateral salpingo-oophorectomy, and with lysis of adhesions. Respondent's medical care of Patient C failed to meet accepted standards of medical practice in the following respects:

1. Respondent performed cryosurgery on Patient C in July 1996 without adequate medical indication, and/or without adequately documenting such medical indication.
2. Respondent, in his discharge summary for the hysterectomy and

related procedures, documented that the patient had a two day hospital stay, and that she had specific laboratory findings of:

- A. "hematocrit 32.2";
- B. "hemoglobin 12.6";
- C. "white blood cell count 6,000";
- D. "Urinalysis benign"; and
- E. "Urine culture negative".

In fact, the patient was discharged on her fifth post-operative day; the laboratory findings cited by the Respondent are not found in any lab report in her admission of January 2000; no urinalysis was ordered or obtained; and no urine culture was ordered or obtained. Respondent knew or should have known these facts.

3. Respondent failed to adequately or accurately document his evaluation and/or treatment of this patient.
- D. Respondent provided medical care to Patient D, a 56 year old female, from 1993 to 1998 at the Respondent's office and at the Community General Hospital. Respondent performed an anterior repair and a Marshall-Marchetti-Krantz procedure on Patient D on or about October 6, 1997. Respondent's medical care of Patient D failed to meet accepted standards of medical practice in the following respects:
1. Respondent failed to adequately evaluate and treat the patient in a timely manner once he had diagnosed her with post-menopausal bleeding in February 1994.
 2. Respondent performed cervical biopsies on the patient in January 1995, without adequate medical indication, and/or without adequately documenting such medical indication.
 3. Respondent performed a diagnostic laparoscopy on the patient in January 1995, without adequate medical indication, and/or without adequately documenting such medical indication.
 4. Respondent performed a hysterectomy on the patient in June 1995 without adequate medical indication, and/or without adequately or accurately documenting such medical indication.
 5. Respondent performed a Marshall-Marchetti-Krantz procedure in October 1997 without adequate medical indication, and/or without

adequately documenting such medical indication.

6. Respondent, in his discharge summary for the Marshall-Marchetti-Krantz and related procedures, documented that the patient had specific laboratory findings of:

- A. "hematocrit 41.5";
- B. "hemoglobin 13.9";
- C. "white blood cell count 7,500";
- D. "Urinalysis benign"; and
- E. "Urine culture negative".

In fact, the laboratory findings cited by the Respondent are not found in any lab report in her admission of October 1997. Respondent knew or should have known these facts.

7. Respondent failed to adequately or accurately document his evaluation and/or treatment of this patient.

E. Respondent provided medical care to Patient E, a 56 year old female, at various times from 1979 through 1999 at the Respondent's office and at the Community General Hospital. Respondent, on or about December 19, 1983, performed cryosurgery on the patient's cervix. Thereafter, on December 2, 1999, Respondent performed a total abdominal hysterectomy, bilateral salpingo-oophorectomy, adhesiolysis, and a Marshall-Marchetti-Krantz procedure, on Patient E. Respondent's medical care of Patient E failed to meet accepted standards of medical practice in the following respects:

1. Respondent performed cryosurgery on Patient E in December 1983 without adequate medical indication, and/or without adequately documenting such medical indication.
2. Respondent obtained cervical biopsies in December 1995 and October 1998 without adequate medical indication and/or without adequately documenting such medical indication.
3. Respondent, in December 1999, performed a Marshall-Marchetti-Krantz procedure on Patient E without adequate medical indication, and/or without adequately documenting such medical indication.
4. Respondent, in his discharge summary for the hysterectomy and related procedures dictated on December 13, 1999, documented

that the patient was discharged on the third day of her hospital stay, that the pathology results were "not available at this time", and that she had specific laboratory findings of:

- A. "hematocrit 31.2";
- B. "hemoglobin 12.6";
- C. "white blood cell count 6,000";
- D. "urinalysis benign"; and
- E. "urine culture negative".

In fact, the patient was discharged on her fourth post-operative day; the laboratory findings cited by the Respondent are not found in any lab report from her admission of December 1999; no urinalysis was ordered or obtained; no urine culture was ordered or obtained; and the pathology report was dated 12/6/99, one week before the Respondent's note. Respondent knew or should have known these facts.

- 5. Respondent failed to adequately or accurately document his evaluation and/or treatment of this patient.
- F. Respondent provided medical care to Patient F, a 43 year old female, at various times from 1979 to 2001 at the Respondent's office and at the Community General Hospital. Respondent performed a diagnostic laparoscopy, dilation and curettage, and obtained cervical biopsies from Patient F on or about February 11, 2000. Respondent's medical care of Patient F failed to meet accepted standards of medical practice in the following respects:
- 1. Respondent, on or about February 11, 2000, performed a diagnostic laparoscopy and obtained cervical biopsies from Patient F without adequate medical indication and/or without adequately documenting such medical indication.
 - 2. Respondent, on or about March 15, 2000, diagnosed Patient F as having "dysplasia", without adequate medical indication. Respondent, on or about April 12, 2000, then inappropriately used cryotherapy on Patient F, which was not medically indicated.
 - 3. Respondent failed to adequately or accurately document his evaluation and/or treatment of this patient.
- G. Respondent provided medical care to Patient G, a 67 year old female, at various times from 1982 through 1997 at the Respondent's office and at Community

General Hospital. Respondent performed surgery on Patient G on December 10, 1996 consisting of a total abdominal hysterectomy, bilateral salpingo-oophorectomy, and a Marshall-Marchetti-Krantz procedure. Respondent's medical care of Patient G failed to meet accepted standards of medical practice in the following respects:

1. Respondent obtained cervical biopsies on October 26, 1985 without adequate medical indication and/or without adequately documenting such medical indication.
2. Respondent, in December 1996, performed a total abdominal hysterectomy/bilateral salpingo-oophorectomy on Patient G without adequate medical indication, and/or without adequately or accurately documenting such medical indication.
3. Respondent, in December 1996, performed a Marshall-Marchetti-Krantz procedure on Patient G without adequate medical indication, and/or without adequately documenting such medical indication.
4. Respondent failed to adequately or accurately document his evaluation and/or treatment of this patient.

H. Respondent provided medical care to Patient H, a 66 year old female, at various times from approximately 1976 through at least 1996 at the Respondent's office and at the Community General Hospital. On or about February 7, 1996, Respondent performed a total abdominal hysterectomy with bilateral salpingo-oophorectomy, adhesiolysis, and a Marshall-Marchetti-Krantz procedure on Patient H. Respondent's medical care of Patient H failed to meet accepted standards of medical practice in the following respects:

1. Respondent obtained cervical biopsies in August 1994 without adequate medical indication and/or without adequately documenting such medical indication.
2. Respondent, between approximately August 1994 and December 1995, treated the patient with Premarin (estrogen therapy) after the

patient's diagnosis of endometrial hyperplasia, without also prescribing a progestogenic agent, which therapy was contraindicated.

3. Respondent, in February 1996, performed a total abdominal hysterectomy on the patient without adequate medical indication and/or without adequately or accurately documenting such medical indication.
4. Respondent, in February 1996, performed a Marshall-Marchetti-Krantz procedure on Patient G without adequate medical indication, and/or without adequately documenting such medical indication.
5. Respondent, in his discharge summary for the February 1996 hysterectomy and related procedures, documented that the patient had a three day hospital stay, and that the patient had specific laboratory findings, including "Urinalysis benign. Urine culture negative". In fact, the patient was discharged on her sixth post-operative day; no urinalysis was ordered or obtained; and no urine culture was ordered or obtained. Respondent knew or should have know these facts.
6. Respondent failed to adequately or accurately document his evaluation and/or treatment of this patient.

SPECIFICATION OF CHARGES

FIRST THROUGH SEVENTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

1. The facts in paragraphs A and A.2 and/or A and A.3.
2. The facts in paragraphs B and B.1, B and B.2, and/or B and B.3.
3. The facts in paragraphs D and D.3, D and D.4, and/or D and D.5.
4. The facts in paragraphs E and E.3.
5. The facts in paragraphs F and F.1.
6. The facts in paragraphs G and G.2, and/or G and G.3.
7. The facts in paragraphs H and H.2, H and H.3, and/or H and H.4.

EIGHTH THROUGH FOURTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

8. The facts in paragraphs A and A.2 and/or A and A.3.
9. The facts in paragraphs B and B.1, B and B.2, and/or B and B.3.
10. The facts in paragraphs D and D.3, D and D.4, and/or D and D.5.
11. The facts in paragraphs E and E.3.
12. The facts in paragraphs F and F.1.

13. The facts in paragraphs G and G.2, and/or G and G.3.
14. The facts in paragraphs H and H.2, H and H.3, and/or H and H.4.

FIFTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

15. The facts in paragraphs A and A.1, A and A.2 (A, B, C, and/or D), A and A.3, A and A.4(A, B, and/or C), A and A.5, B and B.1, B and B.2, B and B.3, B and B.4 (A and/or B), B and B.5, C and C.1, C and C.2(A, B, C, D, and/or E), C and C.3, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6(A, B, C, D, E, and/or F), D and D.7, E and E.1, E and E.2, E and E.3, E and E.4(A, B, C, D, and/or E), E and E.5, F and F.1, F and F.2, F and F.3, G and G.1, G and G.2, G and G.3, G and G.4, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, and/or H and H.6

SIXTEENTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

16. The facts in paragraphs A and A.1, A and A.2 (A, B, C, and/or D), A and A.3, A and A.4(A, B, and/or C), A and A.5, B and B.1, B

and B.2, B and B.3, B and B.4 (A and/or B), B and B.5, C and C.1, C and C.2(A, B, C, D, and/or E), C and C.3, D and D.1, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6(A, B, C, D, E, and/or F), D and D.7, E and E.1, E and E.2, E and E.3, E and E.4(A, B, C, D, and/or E), E and E.5, F and F.1, F and F.2, F and F.3, G and G.1, G and G.2, G and G.3, G and G.4, H and H.1, H and H.2, H and H.3, H and H.4, H and H.5, and/or H and H.6

SEVENTEENTH THROUGH TWENTY- FOURTH SPECIFICATIONS
UNWARRANTED TESTS/TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35) by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

17. The facts in paragraphs A and A.1, and/or A and A.3.
18. The facts in paragraphs B and B.1, B and B.2, and/or B and B.3.
19. The facts in paragraphs C and C.1.
20. The facts in paragraphs D and D.2, D and D.3, D and D.4, and/or D and D.5.
21. The facts in paragraphs E and E.1, E and E.2, and/or E and E.3.
22. The facts in paragraphs F and F.1, and/or F and F.2.
23. The facts in paragraphs G and G.1, G and G.2, and/or G and G.3.
24. The facts in paragraphs H and H.1, H and H.3, and/or H and H.4.

TWENTY- FIFTH SPECIFICATION
FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

25. The facts in paragraphs A and A.1, A and A.2 (A, B, C, and/or D), A and A.3, A and A.4(A, B, and/or C), A and A.5, B and B.1, B and B.2, B and B.3, B and B.4 (A and/or B), B and B.5, C and C.1, C and C.2(A, B, C, D, and/or E), C and C.3, D and D.2, D and D.3, D and D.4, D and D.5, D and D.6(A, B, C, D, E, and/or F), D and D.7, E and E.1, E and E.2, E and E.4(A, B, C, D, and/or E), E and E.5, F and F.1, F and F.3, F and F.5, G and G.1, G and G.2, G and G.3, G and G.4, H and H.1, H and H.3, H and H.4, H and H.5, and/or H and H.6

TWENTY- SIXTH THROUGH THIRTY-FIRST SPECIFICATIONS
FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

26. The facts in paragraphs A and A.2(A, B, C and/or D), and/or A and A.4(A, B, and/or C).
27. The facts in paragraphs B and B.4(A and/or B).
28. The facts in paragraphs C and C.2(A, B, C, D, and/or E).

29. The facts in paragraphs D and D.6(A, B, C, D, and/or E).
30. The facts in paragraphs E and E.4(A, B, C, D, and/or E).
31. The facts in paragraphs H and H.5.

THIRTY SECOND THROUGH THIRTY- SEVENTH SPECIFICATIONS
MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

32. The facts in paragraphs A and A.2(A, B, C and/or D), and/or A and A.4(A, B, and/or C).
33. The facts in paragraphs B and B.4(A and/or B).
34. The facts in paragraphs C and C.2(A, B, C, D, and/or E).
35. The facts in paragraphs D and D.6(A, B, C, D, and/or E).
36. The facts in paragraphs E and E.4(A, B, C, D, and/or E).
37. The facts in paragraphs H and H.5.

DATED: *October*
September 17, 2002
Albany, New York



Peter D. Van Buren

Deputy Counsel

Bureau of Professional Medical Conduct